

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05602

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9m Film G216, 6/6/57 bn

05595

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>1 108 N. POTOMAC ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>ELMER</b> Last <b>AUSHERMAN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/22/1904</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JOHN/AUSHERMAN</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN K. DELAUDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>214-09-9158</b>		17. INFORMANT <b>MRS. SYLVIA AUSHERMAN, HAGERSTOWN, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>acute coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>acute coronary occlusion</b> (c) <b>acute coronary occlusion</b> DUE TO <b>acute coronary occlusion</b> citing the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>5-29-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/1/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 31, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phoebe Rogers</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		WEIGHT		HEIGHT		BUILD		COMPLEXION		HAIR		EYES		EARS		NOSE		MOUTH		TEETH		TONGUE		THROAT		LUNGS		LIVER		SPLEEN		PANCREAS		GASTRIC		INTESTINE		BLADDER		RECTUM		PROSTATE		VAGINA		UTERUS		OVARIES		MILK GLANDS		BREASTS		SKIN		FINGERS		TOES		NAILS		SCARS		TATTOOS		PIGMENTATION		DYSPLASIA		NEVI		MELANOMA		CARCINOMA		LEUKEMIA		LYMPHOMA		MYELOMA		SARCOMA		TUMOR		CYST		ABSCESS		FISTULA		HEMORRHOID		VARICOSE		HEMIPLEGIA		PARALYSIS		EPILEPSY		PSYCHOSIS		DEPRESSION		ANXIETY		PHOBIA		HYPERTENSION		DIABETES		ASTHMA		CORONARY		MISCELLANEOUS	
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RECEIVED  
JUN 3 1957  
BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
05649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05596  
304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		c. LENGTH OF STAY IN life <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hancock</u>	
d. STREET ADDRESS <u>111 W. High Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rhoda</u> Middle <u>Irene</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug. 1, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sullivan-Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob McCarty</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hitchcock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Paul L. Baker- Son</u>		Address <u>Hancock, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio-vascular disease</u> <u>443x</u> DUE TO <u>myocardial heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Little Cove Methodist</u>		22d. LOCATION (City, town, or county) <u>Hancock</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Brown Hancock</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>  </u>		DATE <u>5/20/57</u>	

05-11-1962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 27 1957

RECEIVED



05603

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Barnhart</u> Last <u>Barnhart</u>				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7.8.1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Layton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Laura Barhnart R.F.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> <u>indeterminate</u> DUE TO (b) <u>Arteriosclerosis generalized</u> <u>indeterminate</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>57</u> , to <u>May 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>57</u> , and that death occurred at <u>4:40 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts. Bldg. 6-1-57</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>W. C. Layman</u>				M.D. <u>100 Professional Arts. Bldg. 6-1-57</u>			
PHYSICIAN'S NAME (Type) <u>William T. Layman</u>				<u>Hagerstown</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.3.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dot. Fulton County Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Elmore</u>				ADDRESS <u>Hagerstown Md</u>		24. REC'D BY REGISTRAR <u>June 5, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V.**

JUN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05598

05650

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Williamsport Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Elizabeth</b> Last <b>Bower</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1871</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Shippensburg Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Shippensburg Pa.</b>		
13. FATHER'S NAME <b>Edward Keefer</b>		14. MOTHER'S MAIDEN NAME <b>Frances Shillito</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>---</b>		
17. INFORMANT <b>Miss Joan Bower Williamsport Rt. 2</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 X</b> DUE TO <b>Hypertensive Cordis Vasculosa</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 yrs</b> DUE TO (c) <b>6 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>o. n.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>10-1</b> , 19 <b>56</b> , to <b>5-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5-26-57</b> , 19 <b>57</b> , and that death occurred at <b>7:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>W. Washington St. Hagerstown Md.</b> DATE SIGNED <b>5/26/57</b>				
ACTUAL SIGNATURE <b>Dr. E. E. Ditto Jr</b> M.D. <b>W. Washington St. Hagerstown Md.</b>		DATE SIGNED <b>5/26/57</b>		
PHYSICIAN'S NAME (Type) <b>Dr. E. E. Ditto Jr</b>		W. Washington St. Hagerstown Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-29-57</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>James S. 57</b>		
24b. REGISTRAR'S SIGNATURE <b>E Lee McElroy</b>		DATE <b>5/26/57</b>		

CERTIFICATE OF DEATH

PLACE OF BIRTH MARYLAND		PLACE OF DEATH MARYLAND	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
DATE OF BIRTH JAN 1 1911		DATE OF DEATH JAN 1 1957	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
PLACE OF DEATH HOME		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CORONER [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF JUDGE [Signature]		SIGNATURE OF JUDGE [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF CLERK [Signature]	

BUREAU V. H.

JUN 5 1957

RECEIVED

Item 18 Film 216 6-3-57 ams

05651

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPPANS RURAL</b>				c. LENGTH OF STAY IN 1b <b>17 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRPLAY MD.R.I</b>				d. STREET ADDRESS <b>FAIRPLAY MD.R.I</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GOLDYE GERTRUDE BOWERS</b>				4. DATE OF DEATH Month Day Year <b>MAY 17 1957 19</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>AUGUST 27 1901 55</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>EAKLES CROSS ROADS WASH.CO.MD.U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>CHARLES E. HAMMOND</b>				14. MOTHER'S MAIDEN NAME <b>LEIDA VANASDLAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>WALTER C. BOWERS FAIRPLAY MD.R.I</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Breast cancer</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5/1</b> , 19 <b>57</b> , to <b>5/17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5/16</b> , 19 <b>57</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 W. Potomac</b> DATE SIGNED <b>5/18/57</b>							
ACTUAL SIGNATURE <b>D. J. Bowers</b>				M.D. <b>135 W. Potomac</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 19 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BAKERSVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BAKERSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonshwa Md.</b>				24a. REC'D BY REGISTRAR <b>DATE May 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy shall be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05600

## CERTIFICATE OF DEATH

05652

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Hagerstown</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brook Lane Farm Route 5</u>				STREET ADDRESS (If rural give location) <u>950 Mulberry Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elmer Granville Brandenburg</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>20</u> (Year) <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 1, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown Fred. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion Brandenburg</u>				14. MOTHER'S MAIDEN NAME <u>Laura Routzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>314-09-7789-A</u>		17. INFORMANT & ADDRESS <u>Mrs. Edith Brandenburg, 950 Mulberry Ave. Hagerstown, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
450.0 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 13</u> , 19 <u>57</u> , to <u>May 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>57</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Helmut Tracer</u> M.D.				ADDRESS (Street, city, town, state) <u>Route 5, Hagerstown, Md.</u>			
				DATE SIGNED <u>May 20, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/23/57</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. REC'D BY REGISTRAR DATE <u>May 23, 1957</u>		REGISTRAR'S SIGNATURE <u>Blasht Tracers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. RACE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. TIME OF DEATH		8. CAUSE OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE	
15. SIGNATURE OF SHERIFF		16. SIGNATURE OF CORONER	
17. SIGNATURE OF DEPUTY CLERK		18. SIGNATURE OF DEPUTY REGISTRAR	
19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF DEPUTY REGISTRAR	
21. SIGNATURE OF DEPUTY CLERK		22. SIGNATURE OF DEPUTY REGISTRAR	
23. SIGNATURE OF DEPUTY CLERK		24. SIGNATURE OF DEPUTY REGISTRAR	
25. SIGNATURE OF DEPUTY CLERK		26. SIGNATURE OF DEPUTY REGISTRAR	
27. SIGNATURE OF DEPUTY CLERK		28. SIGNATURE OF DEPUTY REGISTRAR	
29. SIGNATURE OF DEPUTY CLERK		30. SIGNATURE OF DEPUTY REGISTRAR	
31. SIGNATURE OF DEPUTY CLERK		32. SIGNATURE OF DEPUTY REGISTRAR	
33. SIGNATURE OF DEPUTY CLERK		34. SIGNATURE OF DEPUTY REGISTRAR	
35. SIGNATURE OF DEPUTY CLERK		36. SIGNATURE OF DEPUTY REGISTRAR	
37. SIGNATURE OF DEPUTY CLERK		38. SIGNATURE OF DEPUTY REGISTRAR	
39. SIGNATURE OF DEPUTY CLERK		40. SIGNATURE OF DEPUTY REGISTRAR	
41. SIGNATURE OF DEPUTY CLERK		42. SIGNATURE OF DEPUTY REGISTRAR	
43. SIGNATURE OF DEPUTY CLERK		44. SIGNATURE OF DEPUTY REGISTRAR	
45. SIGNATURE OF DEPUTY CLERK		46. SIGNATURE OF DEPUTY REGISTRAR	
47. SIGNATURE OF DEPUTY CLERK		48. SIGNATURE OF DEPUTY REGISTRAR	
49. SIGNATURE OF DEPUTY CLERK		50. SIGNATURE OF DEPUTY REGISTRAR	
51. SIGNATURE OF DEPUTY CLERK		52. SIGNATURE OF DEPUTY REGISTRAR	
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65. SIGNATURE OF DEPUTY CLERK		66. SIGNATURE OF DEPUTY REGISTRAR	
67. SIGNATURE OF DEPUTY CLERK		68. SIGNATURE OF DEPUTY REGISTRAR	
69. SIGNATURE OF DEPUTY CLERK		70. SIGNATURE OF DEPUTY REGISTRAR	
71. SIGNATURE OF DEPUTY CLERK		72. SIGNATURE OF DEPUTY REGISTRAR	
73. SIGNATURE OF DEPUTY CLERK		74. SIGNATURE OF DEPUTY REGISTRAR	
75. SIGNATURE OF DEPUTY CLERK		76. SIGNATURE OF DEPUTY REGISTRAR	
77. SIGNATURE OF DEPUTY CLERK		78. SIGNATURE OF DEPUTY REGISTRAR	
79. SIGNATURE OF DEPUTY CLERK		80. SIGNATURE OF DEPUTY REGISTRAR	
81. SIGNATURE OF DEPUTY CLERK		82. SIGNATURE OF DEPUTY REGISTRAR	
83. SIGNATURE OF DEPUTY CLERK		84. SIGNATURE OF DEPUTY REGISTRAR	
85. SIGNATURE OF DEPUTY CLERK		86. SIGNATURE OF DEPUTY REGISTRAR	
87. SIGNATURE OF DEPUTY CLERK		88. SIGNATURE OF DEPUTY REGISTRAR	
89. SIGNATURE OF DEPUTY CLERK		90. SIGNATURE OF DEPUTY REGISTRAR	
91. SIGNATURE OF DEPUTY CLERK		92. SIGNATURE OF DEPUTY REGISTRAR	
93. SIGNATURE OF DEPUTY CLERK		94. SIGNATURE OF DEPUTY REGISTRAR	
95. SIGNATURE OF DEPUTY CLERK		96. SIGNATURE OF DEPUTY REGISTRAR	
97. SIGNATURE OF DEPUTY CLERK		98. SIGNATURE OF DEPUTY REGISTRAR	
99. SIGNATURE OF DEPUTY CLERK		100. SIGNATURE OF DEPUTY REGISTRAR	

BUREAU V. S.

MAY 27 1957

RECEIVED

NOT JUDICIAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells 05601  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>2 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>436 No Prospect St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TYSON EVERS BRUNNER Sr</u>				4. DATE OF DEATH Month Day Year <u>May 5 1957 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10 1882</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembly Man Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md Pleasant Valley Wash Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Brunner</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-18-2187</u>		17. INFORMANT Address <u>Robert M. Brunner 5 Rosewood Drive Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull (Closed)</u> DUE TO 900.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down the basements stairs</u>					
20c. TIME OF INJURY Month, Day, Year <u>5:30 P. M. May 5 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>				24a. REC'D BY REGISTRAR <u>May 9, 1957</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 15

MAY 13 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05605

## CERTIFICATE OF DEATH

05602

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>811 S. Potomac St.</b>			d. STREET ADDRESS <b>1 Hagerstown</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Austin Burton</b>			4. DATE OF DEATH Month Day Year <b>May 25, 19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1878</b>		9. AGE (In years last birthday) yrs. <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cabinet maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>furniture mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Charlottesville, Va.</b>
13. FATHER'S NAME <b>John A. Burton</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Foster</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-2573</b>		17. INFORMANT <b>Adelbert Burton, Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____, 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>May 11</b> , 19 <b>57</b> , to <b>May 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 27</b> , 19 <b>57</b> , and that death occurred at <b>2115 N.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Eldon G. Hoachlander</b> M.D. <b>Hagerstown Md</b> PHYSICIAN'S NAME (Type) <b>Eldon G. Hoachlander, M.D. 115 W. Washington St., Hag., Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-27-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>			24a. REC'D BY REGISTRAR <b>May 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Brown</b>

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
John A. Harrison		45		Male		White		Caucasian		Roman Catholic		Married		Teacher		Heart Disease		May 23, 1957		Home		John A. Harrison		John A. Harrison		John A. Harrison	
Place of Birth		Date of Birth		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day	
Baltimore, Md.		May 23, 1957		May 23, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Death		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year	
Home		May 23, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Cause of Death		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year	
Heart Disease		May 23, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Death		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year	
Home		May 23, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Cause of Death		Date of Death		Time of Death		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year		Time of Month		Time of Day		Time of Year	
Heart Disease		May 23, 1957		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	

BUREAU V. 3

MAY 31 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 305

05653

05603

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NEAR BOONSBORO</b> c. LENGTH OF STAY IN 1b <b>HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BOONSBORO MD. ROUTE 2.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>north main street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>ALBERT</b> Last <b>CASTLE</b>				4. DATE OF DEATH <b>MAY 27 1957</b> Month <b>May</b> Day <b>27</b> Year <b>19</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 29 1916</b> 9. AGE (In years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MIDDLETOWN FRED. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. ALBERT CASTLE</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. SHEPLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. MARY C. CASTLE BOONSBORO WASH. CO. MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Spine (Lumber)</b> <b>835X</b> DUE TO <b>Crushed thoracic region</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hemorrhage and shock</b> (c) <b>Hemorrhage and shock</b> DUE TO <b>Hemorrhage and shock</b> cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Farm Tractor overturned pinning driver underneath</b>					
20c. TIME OF INJURY Hour <b>12:15</b> P.M. <b>2:30</b> P.M. Month, Day, Year <b>May 27, 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Rural Boonsboro Wash Md</b> (County) <b>Washington</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>MAY 29 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>BOONSBORO WASH. CO. MD.</b>				22e. (State) <b>Md</b>		22f. (Country) <b>U.S.A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barb Friel</b> ADDRESS <b>Home Boonsboro Md</b>				24a. REC'D BY REGISTRAR <b>John H. Bass</b> DATE <b>May 29, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bass</b>	

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JUN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05606

CERTIFICATE OF DEATH

Reg. Dist. No.

05606  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nurseing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jane Pearrell Britner Charlton</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1877</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Berkeley Co., W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac A. Pearrell</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Roger O. Charlton Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>never seen alive</b> , and that death occurred at <b>12:01 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard T. Binford</b>				ADDRESS (Street, city or town, state) <b>1135 Potomac Ave W.D. Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Richard T. Binford</b>				DATE SIGNED <b>6 May 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetary</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>				ADDRESS <b>Martinsburg W. Va.</b>		24a. REC'D BY REGISTRAR <b>MAY 10 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Brown</b>			



continued

briefly

not available.

**Journal Title:**

010220000

Carlock Kussler Home

1990

0781.9 vol. 17. 1970. 200 p. 11 cm. 1 copy.

Page 10 of 10

Berkeley Co. W. Va.

James A. Farrell

Journal of Interpersonal Violence 26(10)

BUREAU V.

MAY 10 1957

RECEIVED

St. Joseph Cemetery

07/07/2015

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05605

05654  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>70 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Benjamin Francis Cline</b>		4. DATE OF DEATH Month Day Year <b>May 11, 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm work</b>	
11. BIRTHPLACE (State or foreign country) <b>Marietta, Ohio</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Levi Cline</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Wolfe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-18-1922</b>	
17. INFORMANT <b>Leroy Cline, Smithsburg RD 1, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/10, 1956</b> to <b>5/11, 1957</b> , that I last saw the deceased alive on <b>5/8, 1957</b> , and that death occurred at <b>10:35</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles Hess, M. D.</b> <b>Smithsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-14-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Hess</b>			

# CERTIFICATE OF DEATH

BUREAU V. 3

May 16 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05606  
302

05655

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>49 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown, Maryland.</b> <b>XO</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cor. Cemetery &amp; Fredrick St.</b>			
d. STREET ADDRESS <b>Cor. Cemetery &amp; Fredrick St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emanuel</b>		First <b>Jacob</b>		Middle <b>Craig</b>		Last	
4. DATE OF DEATH <b>5</b> <b>16</b> <b>19 57</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb 15 1879</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>16</b> Hours <b>19</b> Min. <b>57</b>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Window Washer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>		11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>				13. FATHER'S NAME <b>Jacob Craig</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO. <b>214-09-3225</b>				17. INFORMANT <b>Esther Craig Funkstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma. - Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>151X</b> DUE TO (c) <b>151X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>151X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown, Md.</b>				20g. (County) <b>Hagerstown, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>April 10<sup>th</sup> 1957</b> to <b>May 16<sup>th</sup> 1957</b> , that I last saw the deceased alive on <b>May 10<sup>th</sup> 1957</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b> DATE SIGNED <b>5/17/57</b> ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-18-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr.</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>May 18, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Blair H. Havers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05607

05656

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Ringgold Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 1 Rural, Ringgold</u>		d. STREET ADDRESS <u>Hagerstown #5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown Md., #5</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Keller</u> Last <u>Creager</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/1873</u>
9. AGE (In years last birthday) yrs. <u>83</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vulcan Machine Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ringgold Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Creager</u>		14. MOTHER'S MAIDEN NAME <u>Annie King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Miss Hazel Creager,</u>		Address <u>Ringgold Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardiovascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease - Arterio-Capillary</u> DUE TO (c) <u>Failure - Right Pulmonary collapse</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Shunt</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. <u>  </u> p. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-28-56</u> , 19 <u>  </u> , to <u>5-18-57</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>5-17-57</u> , 19 <u>  </u> , and that death occurred at <u>4:50</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. Lindeman</u>		M.D. <u>Waynesboro Pa</u> DATE SIGNED <u>5-18-57</u>	
PHYSICIAN'S NAME (Type) <u>C. W. LINDEMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ringgold</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Md., #5</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry J. Lane</u>		ADDRESS <u>Waynesboro, Pa</u>	
24a. RECEIVED BY REGISTRAR <u>May 21 57</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John</i>		2. SEX <i>M</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>May 21, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart failure - acute</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
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52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
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79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

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MAY 21 1957  
BUREAU V. 3

15-25-57  
C. W. L. IN DEMAN  
[Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
CERTIFICATE OF DEATH														
Reg. Dist. No. 302														
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland</u>					c. LENGTH OF STAY IN 1b <u>20 yrs.</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland 03</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>					d. STREET ADDRESS <u>421 B. Sumans Ave.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sara Elizabeth Clark</u>					4. DATE OF DEATH Month Day Year <u>May 31 1957</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29 1919</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>					11. BIRTHPLACE (State or foreign country) <u>Washington, Pa.</u>				
13. FATHER'S NAME <u>David Robinson</u>					14. MOTHER'S MAIDEN NAME <u>Myrtle Brookins Hagerstown, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>215-20-8705</u>					17. INFORMANT <u>Mrs. Myrtle Robinson</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Burns of torso &amp; thighs 2+ 3 4 degree</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Coronal Embolism</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>20 days</u> <u>20 days</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bed clothes caught fire</u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Maryland</u>					
21. I certify that I attended the deceased from <u>May 11th., 1957</u> , to <u>May 31st., 1957</u> , that I last saw the deceased alive on <u>May 30th., 1957</u> , and that death occurred at <u>4 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St.</u> DATE SIGNED <u>6/3/57</u>														
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>					M.D. <u>159 W. Washington St., Hagerstown, Maryland</u>									
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr.</u>					ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>June 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shas H. Bowers</u>					

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled with handwritten text.

BUREAU V. 1

JUN 12 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including a date stamp "JUN 12 1957".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05608

## CERTIFICATE OF DEATH

06809  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 Rural Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>R.F.D. # 5</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Isacc</b> Last <b>Coss</b>				4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1904</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Penal Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Leitersburg, Md. Rural</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Coss</b>				14. MOTHER'S MAIDEN NAME <b>Emma Kate Justice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-0898</b>		17. INFORMANT Address <b>Mrs. Thelma A. Coss Hagerstown, Maryland Rt. 5</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Chronic Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis (General)</b> (c) <b>Coronary Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b> <b>2 yrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20, 1957</b> to <b>May 26, 1957</b> , that I last saw the deceased alive on <b>May 26, 1957</b> , and that death occurred at <b>6:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. H. Beachley</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>May 27, 1957</b>			
PHYSICIAN'S NAME (Type) <b>J. H. Beachley</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 3, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		1915		BALTIMORE		BALTIMORE		BALTIMORE		1915		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DATE OF GRADUATION		PLACE OF GRADUATION		CITY OF GRADUATION		COUNTRY OF GRADUATION	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		1910		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		MANAGER		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF OCCUPATION	
BUSINESS		MANAGER		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION		COUNTRY OF OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION	
DATE OF DEATH		1957		JUN		12		1957		BALTIMORE		BALTIMORE		BALTIMORE	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTRY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		1957		JUN		12		1957		BALTIMORE		BALTIMORE		BALTIMORE	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTRY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

JUN 12 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05609

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>50 years</u>		d. STREET ADDRESS <u>400 Summit Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mollers Apts. 400 Summit Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Margaret</u> Middle <u>Gack</u> Last <u>Gack</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1877</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>County Cork, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sweeney</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Viola R. Stitley, Hagerstown, Md.</u>		Address <u></u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>? 10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/19/54</u> 19 <u>54</u> , to <u>5/12/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5/12/57</u> 19 <u>57</u> , and that death occurred at <u>12 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. L. Campbell</u>		M.D. <u>145 W Washington St</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>5/13/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert V. L. Campbell</u>		<u>Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. P. Rouzer</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. Bowers</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05610

CERTIFICATE OF DEATH

05609

Reg. Dist. No.

3021

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>13 N. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Florence</b> Last <b>Gardner</b>		4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1874</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cavetown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Reynolds</b>		14. MOTHER'S MAIDEN NAME <b>Sally Reynolds</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>George H. Gardner, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) <b>10 yrs.</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>54</b> , to <b>5/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>57</b> , and that death occurred at <b>1:30</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M. D.</b> <b>Smithsburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-3-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>May 3, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED George H. Gagner		DATE OF DEATH May 10, 1957	
AGE 65		SEX Male	
RACE White		EDUCATION High School	
BIRTHPLACE Maryland		RESIDENCE Baltimore, Maryland	
DATE OF BIRTH May 10, 1892		PLACE OF BIRTH Baltimore, Maryland	
MARRIAGE Married		SPOUSE Mary H. Gagner	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
SIGNATURE OF DECEASED George H. Gagner		SIGNATURE OF WITNESS Mary H. Gagner	
DATE OF SIGNATURE May 10, 1957		DATE OF SIGNATURE May 10, 1957	
PLACE OF SIGNATURE Baltimore, Maryland		PLACE OF SIGNATURE Baltimore, Maryland	
SIGNATURE OF PHYSICIAN Dr. J. H. Gagner		SIGNATURE OF CLERK J. H. Gagner	
DATE OF SIGNATURE May 10, 1957		DATE OF SIGNATURE May 10, 1957	
PLACE OF SIGNATURE Baltimore, Maryland		PLACE OF SIGNATURE Baltimore, Maryland	

BUREAU V. 3

MAY 6 1957

RECEIVED

05657

CERTIFICATE OF DEATH

06815

Reg. Dist. No. 396

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>				c. LENGTH OF STAY IN 1b <b>65 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KEEDYSVILLE MD.</b>				d. STREET ADDRESS <b>KEEDYSVILLE MD.</b>			
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>E.</b> Last <b>GEETING</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 22 1869</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED C. HUFFER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH TOMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RUSSEL H. GEETING KEEDYSVILLE MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>February 10, 1957</b> to <b>May 16, 1957</b> , that I last saw the deceased alive on <b>May 16, 1957</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Lelvan</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro Maryland</b> DATE SIGNED <b>5/18/57</b>			
PHYSICIAN'S NAME (Type) <b>G. W. Lelvan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MAY 19 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>KEEDYSVILLE WASH.CO.MD.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bad Funeral Home</b> ADDRESS <b>Boonsboro Md</b>				24a. REC'D BY REGISTRAR <b>DATE 5/20/57</b>	24b. REGISTRAR'S SIGNATURE <b>Bob Geeting</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



JUL 1 1957

RECEIVED



05658

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>			c. LENGTH OF STAY IN 1b <b>18 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Hagerstown Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeders Nursing Home</b>				d. STREET ADDRESS <b>Route 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daisy Dean Gerhart</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Big Pool Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Frank Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Repp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Mrs. Nellie V. Eyler</b> Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>no.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b> <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Washington</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>May 5</b> , 19 <b>57</b> , and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 East Antietam St. Hagerstown Md.</b> DATE SIGNED <b>5/6/57</b>							
ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D. <b>119 E. Antietam St.</b>				PHYSICIAN'S NAME (Type) <b>Dr. Louis G. Graff</b> <b>119 East Antietam St. Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Clearspring Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 11 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Boevers</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

<p>1. Name of Deceased: <b>Washington</b></p>		<p>2. Sex: <b>Male</b></p>	
<p>3. Date of Birth: <b>18 months</b></p>		<p>4. Place of Birth: <b>Boston</b></p>	
<p>5. Date of Death: <b>1957</b></p>		<p>6. Place of Death: <b>Boston</b></p>	
<p>7. Cause of Death: <b>Heart Disease</b></p>		<p>8. Manner of Death: <b>Natural</b></p>	
<p>9. Signature of Physician: <b>Dr. J. J. [illegible]</b></p>		<p>10. Signature of Registrar: <b>[illegible]</b></p>	
<p>11. Date of Registration: <b>1957</b></p>		<p>12. Place of Registration: <b>Boston</b></p>	

BUREAU V. 8

14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05659

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05611

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2 Rural Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>Emil Michael Gertz</b>		d. STREET ADDRESS <b>Route 6</b>	
4. DATE OF DEATH <b>May 22 19 57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1888</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael Gertz</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Schneider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes W. W. 1</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Sheriff Office</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic coronary thrombosis</b> DUE TO <b>Tuberculosis of lungs with cavity formation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old pulmonary Embolism</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>N one 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-24-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-24-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnick &amp; Sons</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 27 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank T. Bowers</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John J. Anderson		AGE 6 yrs.		SEX Male		RACE White		DATE OF DEATH May 17, 1957		PLACE OF DEATH Home	
RESIDENCE House 10		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201		MANNER OF DEATH Natural	
CAUSE OF DEATH Sudden Infant Death Syndrome		IMMEDIATE CAUSE SIDS		MIDDLE CAUSE SIDS		UNDERLYING CAUSE SIDS		OTHER CAUSE None		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		TITLE Medical Examiner		OFFICE Baltimore Office		DATE May 17, 1957		TIME 10:00 AM		PLACE Baltimore	

**RECEIVED**  
 MAY 29 1957  
 BUREAU V. S.

05611

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Unnamed baby boy of Robert Goff</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7 1957</b>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <b>1</b> Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Md Hagerstown Wash. Co</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Robert Goff</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert Goff 164 W. Washington St Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Premature Delivery - Section</b> (c) <b>Partial Premature Separation Placenta</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 King St. Hagerstown</b> DATE SIGNED <b>5-9-57</b>							
ACTUAL SIGNATURE <b>Samuel F. Waddell</b>				PHYSICIAN'S NAME (Type) <b>Samuel F. Waddell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>May 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

File No. 15

MAY 15 1957

BUREAU V. S.

RECEIVED

RECEIVED MAY 15 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05660

## CERTIFICATE OF DEATH

06817

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Security</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Security</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>516 Antietam Drive</b>		d. STREET ADDRESS <b>516 Antietam Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W.</b> Last <b>GRIMM</b>		4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles M. Grimm</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Holmes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-5111</b>	
17. INFORMANT <b>Mrs. Edward Ridenour</b>		Address <b>1126 Security Rd. Security, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Heart Disease with</b> <b>420.0</b> DUE TO <b>Myocardial Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 1952, to <b>31 May</b> , 1957, that I last saw the deceased alive on <b>31 May</b> , 1957, and that death occurred at <b>5:45 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. F. Lusby</b>		ADDRESS (Street, city or town, state) <b>2301 Potomac</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>		DATE SIGNED <b>1 Jun 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 3/1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. C. Honor C. M.</b>			

WALLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD  
 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. WALLAND		65		M		W		JAN 15 1892		BALTIMORE		MD		MD		USA	
RESIDENT OF		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
1234 E. BALTIMORE ST.		JUN 10 1957		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
CLERK		HIGH SCHOOL		MARRIED		JAN 15 1915		JAN 15 1915		JAN 15 1915		JAN 15 1915		JAN 15 1915		JAN 15 1915	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH	
JAMES H. WALLAND		MARY H. WALLAND		CLERK		HOUSEWIFE		BALTIMORE		BALTIMORE		JAN 15 1865		JAN 15 1875		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DISEASE OR INJURY	
JAN 15 1945		JAN 15 1945		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DISEASE OR INJURY		MOTHER'S DISEASE OR INJURY		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DISEASE OR INJURY	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

RECEIVED  
 JUN 12 1957  
 BUREAU V. 3

05612

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>47 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>926 Mt. Etna Road</u>				d. STREET ADDRESS <u>926 Mt. Etna Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>GRACE</u> Last <u>GROSSNICKLE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Caleb H. Grossnickle</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte A. Kinna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mary E. Grossnickle, Hagerstown, Md.</u>				18. ADDRESS <u>930 Mt. Etna Road,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arricular Fibrillation due to Arterio</u> DUE TO (c) <u>sclerotic heart disease</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>few months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 Apr</u> , 19 <u>57</u> , to <u>16 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 May</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F F Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac</u>			
DATE SIGNED <u>17 May 57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Frank F. Lusby</u>				230 N. Potomac St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grossnickle's</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>				ADDRESS <u>Myersville, Md.</u>		24a. REC'D BY REGISTRAR <u>May 19 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>B. H. Bowers</u>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED <b>JOHN A. SMITH</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>	
4. DATE OF DEATH <b>MAY 15 1957</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. PLACE OF BIRTH <b>BALTIMORE, MD</b>	
10. OCCUPATION <b>CLERK</b>		11. MARITAL STATUS <b>MARRIED</b>		12. EDUCATION <b>HIGH SCHOOL</b>	
13. PREVIOUS ILLNESS <b>NO</b>		14. PRESENT ILLNESS <b>NO</b>		15. SIGNATURE OF DECEASED <b>[Signature]</b>	
16. SIGNATURE OF WITNESSES <b>[Signature]</b>		17. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		18. SIGNATURE OF CORONER <b>[Signature]</b>	
19. SIGNATURE OF JURY <b>[Signature]</b>		20. SIGNATURE OF JUDGE <b>[Signature]</b>		21. SIGNATURE OF CLERK <b>[Signature]</b>	

BUREAU V. 3

MAY 20 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05613

## CERTIFICATE OF DEATH

Reg. Dist. No.

05614

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03		d. STREET ADDRESS <u>985 Jefferson Blvd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>Kate</u> Last <u>Grove</u>		4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Henry Stull</u>		14. MOTHER'S MAIDEN NAME <u>Emma K. Kidwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Henry Carroll</u>		Address <u>985 Jefferson Blvd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Leg &amp; Gangrene</u> <u>450.1</u> DUE TO <u>Arterio Sclerosis (General)</u> 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X Sclerotic Arterio Sclerosis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 20, 1957</u> , that I last saw the deceased alive on <u>May 23, 1957</u> , and that death occurred at <u>10:15 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, MD</u> DATE SIGNED <u>May 24/57</u> ACTUAL SIGNATURE <u>J. H. Beachley</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Jack H. Beachley M. D.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>May 26, '57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Leaf Williamsport, Md</u> 24. REC'D BY REGISTRAR <u>May 24 1957</u> 24a. REGISTRAR'S SIGNATURE <u>Walter Leaf Williamsport, Md</u>			

**BUREAU V. S.**

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05615

05614

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md. X2	
d. STREET ADDRESS 21 W. Potomac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Susan Elsie Grove		4. DATE OF DEATH Month Day Year May 27 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12 1881	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 9 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Lemen		14. MOTHER'S MAIDEN NAME Annie Busey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Joseph G. Grove		Address Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/26/57, 19, to 5/27/57, 19, that I last saw the deceased alive on 5/27/57, 19, and that death occurred at 10:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Young M.D.		DATE SIGNED 5/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		ADDRESS Williamsport, Md.	
24a. REC'D BY REGISTRAR May 29, 1957		24b. REGISTRAR'S SIGNATURE L. H. Bowers	

BUREAU V. S.

JUN 3 1957

RECEIVED

05615

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>29 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAULINE</b> Middle <b>LUCINDA</b> Last <b>HEALEY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/1918</b>	9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PAUL S. GLUCK</b>				14. MOTHER'S MAIDEN NAME <b>MARY RINEDOLLAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-30-3926</b>		17. INFORMANT <b>MR. RALPH HEALEY</b> <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Abdominal Cancer</b> <b>175x</b> DUE TO <b>Adenocarcinoma of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>7 mos</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-28-48</b> , 19____, to <b>5-10-57</b> , 19____, that I last saw the deceased alive on <b>5-10-57</b> , 19____, and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>5/12/57</b> ACTUAL SIGNATURE <b>S. EARL YOUNG</b> PHYSICIAN'S NAME (Type) <b>S. EARL YOUNG</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>May 15, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

MAY 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05616

## CERTIFICATE OF DEATH

05617

Reg. Dist. No. 342

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>40YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>NEWTON</b> Last <b>HENSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/12/1915</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLYDE HENSON</b>		14. MOTHER'S MAIDEN NAME <b>GRACE MESSER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-4983</b>	
17. INFORMANT <b>MRS. NELLIE HENSON</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V. disease</b> DUE TO (c) <b>UnKnown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X None</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 6</b> , 19 <b>55</b> , to <b>May 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. L. Packer Jr.</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>5/25/57</b>	
PHYSICIAN'S NAME (Type) <b>L. L. PACKER JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/26/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md</b>		24a. REC'D BY REGISTRAR <b>May 27, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HENSON		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH JAN 15 1910		PLACE OF BIRTH NEW YORK	
MARRIAGE MARRIED		OCCUPATION FARMER		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH MAY 15 1957		PLACE OF DEATH HOME		TIME OF DEATH 10:30 AM		TEMPERATURE 100.0		PULSE 100		RESPIRATION 20	
SIGNATURE OF DECEASED JAMES H. HENSON		SIGNATURE OF WITNESS JAMES H. HENSON		SIGNATURE OF PHYSICIAN JAMES H. HENSON		SIGNATURE OF CLERK JAMES H. HENSON		SIGNATURE OF REGISTRAR JAMES H. HENSON		SIGNATURE OF JUDGE JAMES H. HENSON	

BUREAU V. 2

MAY 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05618

Reg. Dist. No. 301

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River Dam at P.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Oliver</u> Last <u>High</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1939</u>
9. AGE (In years last birthday) <u>17 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tree Trimming</u>	
11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. West Vir. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph High</u>		14. MOTHER'S MAIDEN NAME <u>Lillian O'Neal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-2166</u>	
17. INFORMANT <u>Ralph High</u>		Address <u>Marlowe, West Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Suffocation by drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while trying to rescue boat in water</u>	
20c. TIME OF INJURY Month, Day, Year <u>Noon</u> <u>May 3</u> <u>19 57</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u>	20f. (City or town) (County) (State) <u>Williamsport</u> <u>Wash</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 9, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marlowe West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williamsport, Md</u>		24a. REC'D BY REGISTRAR <u>May 9-1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF NURSE		18. SIGNATURE OF CHAPLAIN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF OTHER	

**RECEIVED**  
 MAY 13 1957  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05619

05617

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>50YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>457 SUMMIT AVE.</b>		d. STREET ADDRESS <b>457 SUMMIT AVE.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES CLINTON HOFFMASTER</b>		4. DATE OF DEATH Month Day Year <b>MAY 24 19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/1879</b>
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE GROCER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL HOFFMASTER</b>		14. MOTHER'S MAIDEN NAME <b>MARY ROHRER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-7708A</b>	
17. INFORMANT Address <b>HAGERSTOWN MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-1955</b> to <b>5-24-1957</b> that I last saw the deceased alive on <b>4-27-57</b> , 19 <b>57</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Dr. E. W. Hitt Jr.</b> M.D. <b>Dr. E. W. Hitt Jr.</b> PHYSICIAN'S NAME (Type) <b>Hagerstown Md.</b> <b>Hagerstown Md.</b> <b>5/24/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SHARPSBURG MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. J. Norment, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 28, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BASTARD OR 18

NAME OF DECEASED SAMUEL HOPKINS		AGE 61		SEX MALE		RACE WHITE		DATE OF DEATH MAY 31 1957	
PLACE OF DEATH Baltimore, Md.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		MORBIDITY CODE 010	
DECEASED'S RESIDENCE 1234 N. Main St.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S OCCUPATION None		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S MARITAL STATUS Married		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH DATE 1896		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH PLACE Baltimore, Md.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH NAME Samuel Hopkins		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH DATE 1896		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH PLACE Baltimore, Md.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
DECEASED'S BIRTH NAME Samuel Hopkins		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	

BUREAU V. S.

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05662

## CERTIFICATE OF DEATH

05620

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>		c. LENGTH OF STAY IN 1b <u>30 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING RT 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLEAR SPRING RT 2</u>				d. STREET ADDRESS <u>ROUTE 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>IRENE</u> Last <u>HOSE</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1903</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAUEL REED</u>				14. MOTHER'S MAIDEN NAME <u>PET BLOYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>RUSSELL F. HOSE</u> Address <u>CLEAR SPRING RT 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Diabetes mellitus 2. Nephrosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27, 1956</u> , to <u>May 2, 1957</u> , that I last saw the deceased alive on <u>April 1, 1956</u> , and that death occurred at <u>3:75 am</u> on <u>May 2, 1957</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> <u>Clear Spring, Maryland</u> <u>5/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLAIRS VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> <u>Clear Spring, Md</u>				24a. REC'D BY REGISTRAR <u>May 4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. CITY OF BIRTH [Illegible]		7. COUNTY OF BIRTH [Illegible]		8. STATE OF BIRTH [Illegible]	
9. OCCUPATION [Illegible]		10. MARITAL STATUS [Illegible]		11. COLOR [Illegible]		12. RELIGION [Illegible]	
13. CAUSE OF DEATH [Illegible]		14. MANNER OF DEATH [Illegible]		15. PLACE OF DEATH [Illegible]		16. DATE OF DEATH [Illegible]	
17. SIGNATURE OF PHYSICIAN [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]		19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF DECEASED [Illegible]	

BUREAU V. 8

MAY 7 1957

RECEIVED

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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05663

CERTIFICATE OF DEATH

Reg. Dist. No.

05621  
30.4

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>		c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hancock Maryland.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Melvin</u> Last <u>Iden</u>		4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8.23.1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming ((Retired))</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Morgan County W.VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Parkson Iden</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Iden.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Katherine R Collins</u>		Address <u>Hancock Md. 200 E. Terrace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary disease</u> <u>arterio Sclerosis</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>2da</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/22 19 57</u> to <u>5/24/57</u> , that I last saw the deceased alive on <u>5/22/57</u> , 19 <u>57</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.M. Shopper</u>		ADDRESS (Street, city or town, state) <u>Hancock Md</u>	
DATE SIGNED <u>5/24/57</u>			
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.26.57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stotlers Cross Roads W.VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>		ADDRESS <u>Hancock Md</u>	
24a. RECEIVED BY REGISTRAR <u>5/24/57</u>		DATE <u>5/24/57</u>	
24b. REGISTRAR'S SIGNATURE <u>McNeller</u>			



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 3

MAY 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05664 CERTIFICATE OF DEATH

Reg. Dist. No.

05622  
347

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>5 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanatorium</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EDNA</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State, county, city or town) <b>Montgomery Co Gaithersburg Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Garrett</b>		14. MOTHER'S MAIDEN NAME <b>Mary H. Byrne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ernest Johnson 808 W. Franklin St</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1-56</b> , 19 <b>56</b> , to <b>5-26-1957</b> , that I last saw the deceased alive on <b>5-24-1957</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. F. W. Dittus</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. F. W. Dittus</b>		DATE SIGNED <b>6/2/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery Gaithersburg Montgomery Co Md</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>John 357</b>		24b. REGISTRAR'S SIGNATURE <b>Lee M. Elroy</b>	

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05618

## CERTIFICATE OF DEATH

Reg. Dist. No.

05623

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
c. LENGTH OF STAY IN 1b <b>12 YEARS</b>		d. STREET ADDRESS <b>1062 SOUTH POTOMAC STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1062 SOUTH POTOMAC STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BESSIE MAE KEPHART</b>		4. DATE OF DEATH Month Day Year <b>MAY 4 1957 19</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 7 1899</b> yrs. <b>57</b>
9. AGE (In years lost birthday) <b>57</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>HARMONY FRED. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD L. BABBINGTON</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE V. HARSHMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217 32 5349</b>	
17. INFORMANT <b>JOHN T. KEPHART</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO <b>10 yrs.</b> (c) <b>and Arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>443x</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 8, 1956</b> , to <b>May 4, 1957</b> , that I last saw the deceased alive on <b>Feb 7, 1957</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>217 W. Washington St., Hagerstown, Md.</b>		DATE SIGNED <b>5/6/57</b>	
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>		M.D. <b>217 W. Washington St., Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>MAY 7 1957</b>	<b>LUTHERAN CEMETERY</b>	<b>MIDDLETOWN FRED. CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home Boonsboro Wash. Co. Md.</b>		24a. REC'D BY REGISTRAR <b>May 9, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		AGE [REDACTED]	
SEX [REDACTED]		RACE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]	
CITY OF DEATH [REDACTED]		COUNTY OF DEATH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		TREATMENT [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF DEATH REGISTRAR [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	

BUREAU V. H.

MAY 18 1957

RECEIVED



05619

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		d. STREET ADDRESS <b>2006 Virginia Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>DOUGLAS</b> Last <b>LEFEVER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Lefever</b>		14. MOTHER'S MAIDEN NAME <b>Mary Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Minnie K. Lefever</b>		Address <b>2006 Virginia Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>arteriosclerotic myocardial heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b> <b>Diabetes M.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>5yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1952</b> , to <b>May 10, 1957</b> , that I last saw the deceased alive on <b>May 9, 1957</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>5-10-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

MAY 15 1957

RECEIVED

Andrew A. Gorman Hagerstown Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05665

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Smithsburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foxville, Maryland 10 X 22</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>County Road near Smithsburg</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Roscoe</u> Last <u>Lewis</u>			4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1937</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Roscoe Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Lewis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1955-1957 214-34-9716</u>		17. INFORMANT <u>Sister via</u> Address <u>Creager's Funeral Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull and internal injuries</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of auto. pinned under wreck.</u>			
20c. TIME OF INJURY Month, Day, Year <u>5/2 1957</u> Hour <u>1:00</u> a. m. <u>pm</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>County Road Smithsburg, Washing. Md.</u>	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Bethel Methodist Cem. Near Garfield, Frank Co.</u>	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>			24a. REC'D BY REGISTRAR <u>  </u>		
ADDRESS <u>Thurmont, MD</u>			24b. REGISTRAR'S SIGNATURE <u>  </u>		
DATE <u>May 6 57</u>					

BUREAU V. S.

MAY 6 1957

RECEIVED

05666

CERTIFICATE OF DEATH

05626

Reg. Dist. No. 313

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penn</b> b. COUNTY <b>Fulton</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McConnellsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>		d. STREET ADDRESS <b>75X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Catherine</b> Last <b>Lininger</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Foulton Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Michael Kanuff</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Barmont</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nettie Booth</b> Address <b>McConnellsburg Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Endocarditis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>430.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 17, 1957</b> to <b>May 12, 1957</b> , that I last saw the deceased alive on <b>May 11, 1957</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>5/13/57</b>	
PHYSICIAN'S NAME (Type) <b>David Brewer</b>		<b>Clearspring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-15-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mc Connellsburg Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 18-57</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fickler</b> (Deputy)	



CERTIFICATE OF DEATH

Name of Deceased <b>David Brown</b>		Sex <b>Male</b>		Age <b>45</b>	
Date of Birth <b>1912</b>		Place of Birth <b>Union Cemetery</b>		Race <b>White</b>	
Cause of Death <b>Heart Disease</b>		Duration of Illness <b>10 days</b>		Date of Death <b>April 23, 1957</b>	
Place of Death <b>Home</b>		Name of Physician <b>Dr. J. H. Smith</b>		Signature of Physician <i>[Signature]</i>	
Name of Informant <b>John Doe</b>		Relationship <b>Brother</b>		Signature of Informant <i>[Signature]</i>	
Address <b>123 Main St.</b>		City <b>Baltimore</b>		State <b>Md.</b>	
County <b>Harford</b>		Municipality <b>Union Cemetery</b>		Burial Place <b>Union Cemetery</b>	
Date of Burial <b>April 25, 1957</b>		Name of Burial Place <b>Union Cemetery</b>		Signature of Burial Place <i>[Signature]</i>	
Name of Undertaker <b>John Doe</b>		Signature of Undertaker <i>[Signature]</i>		Date of Certificate <b>April 23, 1957</b>	
Name of Registrar <b>John Doe</b>		Signature of Registrar <i>[Signature]</i>		Date of Registration <b>April 23, 1957</b>	

BUREAU V. 31

APR 23 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>124 EAST AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>AMELIA</b> Last <b>LIZER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>NORMAN BOWERS</b>	
14. MOTHER'S MAIDEN NAME <b>HENRETTA STAUBS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. MILDRED MORRISON HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>14 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 9, 19 56</b> to <b>May 26, 19 57</b> , that I last saw the deceased alive on <b>May 25, 19 57</b> , and that death occurred at <b>12:50 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b> DATE SIGNED <b>5-27-57</b>			
ACTUAL SIGNATURE <b>R. A. Bell</b>		M.D. <b>119 North Potomac St. Hagerstown, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>			
22a. BURIAL, CREMATION, or other (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant</b>		24a. REC'D BY REGISTRAR <b>May 31, 1957</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU Y. K.**

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05628

05621

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY in 1b <u>12 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> 03		d. STREET ADDRESS <u>836 Spruce Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>836 Spruce Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Jane</u> Last <u>Mc Elroy</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u> Hours <u>    </u> Min. <u>    </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Taylors Landing Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mc Coy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. George McElroy</u>		Address <u>836 Spruce St. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>    </u> DUE TO (c) <u>    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>    </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/12/57</u> to <u>5/13/57</u> , that I last saw the deceased alive on <u>5/13/57</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.		DATE SIGNED <u>5/13/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert J. Wolf Williamsport Md</u>		24a. REC'D BY REGISTRAR <u>May 14 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Shaftt Roward</u>	

BUREAU V. 3

1957 64 180

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05622

## CERTIFICATE OF DEATH

05629

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 16 S. MULBERRY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE BELLE McKINSEY		4. DATE OF DEATH MA YBERT. 27 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/28/1892
9. AGE (In years last birthday) 64rs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY WOLFE		14. MOTHER'S MAIDEN NAME CORA DELAUDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT LOUISE McKINSEY, HAGERSTOWN, MD.		Address	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X DUE TO Carcinoma of Vaginal wall Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastasis to large bowel DUE TO Intestinal obstruction (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 17 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1942, to May 27, 1957, that I last saw the deceased alive on May 27, 1957, and that death occurred at 10:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Robert Wells		M.D. 115 N. Potomac Street 5-28-57	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/30/57	
22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEMETERY		22d. LOCATION (City, town, or county) SMITHSBURG MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horwath		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR May 31 1957		24b. REGISTRAR'S SIGNATURE Blanche Powers	

# CERTIFICATE OF DEATH

1957

STATE OF MARYLAND - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
40 YRS		M	
PLACE OF BIRTH		DATE OF BIRTH	
MEMPHIS, TENN		MAY 1928	
OCCUPATION		EDUCATION	
ATTORNEY		HIGH SCHOOL	
MARRIAGE		PREVIOUS MARRIAGES	
MARRIED		NONE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL CAUSE	
PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MD		MAY 14 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
MAY 14 1968		MAY 14 1968	

BUREAU V. 1

JUN 3 1957

RECEIVED



BUREAU V. S.

MAY 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05624

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells

Reg. Dist. No. 05631 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Cty. Hospital</u>		d. STREET ADDRESS <u>2005 Penna. Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Grace</u> Last <u>McNairn</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1908</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H. Petre</u>		14. MOTHER'S MAIDEN NAME <u>Mary Byers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-1182</u>	
17. INFORMANT <u>John D. McNairn</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u> DUE TO <u>Vascular hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-20-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long Meadow Cemetery</u>		22d. LOCATION (City, town, or county) <u>Paramount, Md.</u> (State) <u>Wash. Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>May 20, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>S. Robert Wells</u>	

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140



BUREAU V. M.

MAY 23 1957

RECEIVED

05667

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

05632

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairplay Md.</u>			c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairplay Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairplay Md.</u>				d. STREET ADDRESS <u>Fairplay Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>May</u> Last <u>Moats</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct, 18 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Moats</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Hezekiah Moats Fairplay Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>56</u> , to <u>7 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7 May</u> , 19 <u>57</u> , and that death occurred at <u>12:15</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Patomac Str. Williamsport, Md.</u> DATE SIGNED <u>9 May 57</u>							
ACTUAL SIGNATURE <u>Paul Haak</u>				M.D. <u>Williamsport, Md.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert J. Wolf Williamsport Md.</u>				24a. REC'D BY REGISTRAR DATE <u>May 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bost</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 31

MAY 15 1957

RECEIVED

6841

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN IB <b>10 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				d. STREET ADDRESS <b>540 Summit Ave.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Lee</b> Last <b>Moats</b>				4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchilds</b>		11. BIRTHPLACE (State or foreign country) <b>Tilghmanton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Moats</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Rohrer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-8464</b>		17. INFORMANT <b>Mrs. Carl L. Moats</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 29, 19 57</b> to <b>May 29, 19 57</b> , that I last saw the deceased alive on <b>May 29, 19 57</b> , and that death occurred at <b>9:10A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St., Hagerstown, Maryland.</b> DATE SIGNED <b>May 31, 1957</b>							
ACTUAL SIGNATURE <i>R. A. Bell</i>		M.D. <b>R. A. Bell, M. D.</b>					
PHYSICIAN'S NAME (Type)		<b>Hagerstown, Maryland.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Free W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>June 3, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>Black Bowers</i>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
George Horner		April 10, 1957	
Age		Sex	
65		Male	
Race		Color	
White		White	
Place of Birth		Date of Birth	
Tilghman, Md.		April 10, 1892	
Usual Residence		Date of Residence	
Tilghman, Md.		April 10, 1957	
Cause of Death		Manner of Death	
Heart Failure		Natural	
Immediate Cause		Underlying Cause	
Heart Failure		Heart Failure	
Contributing Cause		Contributing Cause	
Hypertension		Hypertension	
Duration of Illness		Date of Admission	
10 days		April 1, 1957	
Place of Death		Date of Death	
Home		April 10, 1957	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

**RECEIVED**  
JUN 12 1957  
BUREAU V. 3

FILED JUN 11 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05625

## CERTIFICATE OF DEATH

Dr. L.L. Packer  
05633  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>143 Alexander Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IRA CLAY MYERS</b>				4. DATE OF DEATH Month Day Year <b>May 21, 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 25/1894</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor W.R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Millstone .Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Myers</b>				14. MOTHER'S MAIDEN NAME <b>Della Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>705-10-5348</b>		17. INFORMANT Address <b>Mrs Belva H. Myers 143 Alexander St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrotic disease</b> DUE TO (c) <b>Hypertensive C.V. disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>593X</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>April 3, 1957</b> , to <b>May 21, 1957</b> , that I last saw the deceased alive on <b>May 21, 1957</b> , and that death occurred at <b>6:27 pm</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>L. L. Packer</b> M.D. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/24.57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Little ROSE HILL Cem. Near Clearspring, Md</b>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 25, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowser</b>

MAY 28 1957

RECEIVED

05626

## CERTIFICATE OF DEATH

Dr Brewer

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 Days</u> <u>X</u> <u>Big Pool</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>			d. STREET ADDRESS -----		
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>MYERS</u>			4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Big Pool Wash. Co Md</u>	
13. FATHER'S NAME <u>Henry J. Myers</u>			14. MOTHER'S MAIDEN NAME <u>Ellen Myers</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Bessie Myers Big Pool Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Bronchial Asthma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Nov 15, 1956</u> to <u>May 5, 1957</u> , that I last saw the deceased alive on <u>May 5, 1957</u> , and that death occurred at <u>59</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.			ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>5/6/57</u>		
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Shanktown Wash. Co Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>May 9, 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>Charles H. Powers</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. 4

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 4215 5-15-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

05627  
05635  
302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>63 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 Broadway</b>			d. STREET ADDRESS <b>1 29 Broadway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William Hamilton Hauer Needy</b>			4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1877</b>		9. AGE (In years last birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store-owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>		11. BIRTHPLACE (State or foreign country) <b>Broadfording Wash. Md.</b>	
13. FATHER'S NAME <b>Samuel Needy</b>			14. MOTHER'S MAIDEN NAME <b>Louise Hauer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-32-4526</b>		17. INFORMANT <b>W. H. Needy</b> Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar 7, 1952</b> , to <b>May 8, 1957</b> , that I last saw the deceased alive on <b>May 8, 1957</b> , and that death occurred at <b>11:19 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Robert P. Conrad</b>		M.D. <b>137 W. Wash. Hagerstown, Md.</b>		DATE SIGNED <b>5-10-57</b>	
PHYSICIAN'S NAME (Type) <b>Robert P. Conrad 137 W. Washington St. Hagerstown Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 13, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shirley Bowers</b>	

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1957

Name of Deceased HARRISON, ROBERT J.		Sex Male		Age 40 Years	
Date of Death May 15, 1957		Place of Death 22 Broadway		City Baltimore	
Cause of Death Heart Disease		Manner of Death Natural		Occupation None	
Signature of Physician H. H. Hooton, M.D.		Signature of Registrar H. H. Hooton		Signature of Coroner H. H. Hooton	
Date of Report May 15, 1957		Time of Report 10:00 AM		Place of Report Baltimore	

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MAY 15 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05628

## CERTIFICATE OF DEATH

DR W. D. Campbell 05636

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN TB <b>14 Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 West Side Ave</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>19 West Side Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HENRY NUSSEAR Sr</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 24 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Foreman W.M.R.R. Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Md. Emmitsburg Fred, Con</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jesse H. Nussear</b>	
14. MOTHER'S MAIDEN NAME <b>Mary C. wierlok</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>705-10-4989</b>	
16. SOCIAL SECURITY NO. <b>705-10-4989</b>		17. INFORMANT <b>John H. Nussear Jr.</b> Address <b>19 West Side Ave Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-Vascular Disease</b> DUE TO (c) <b>10 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 5</b> , 19 <b>48</b> , to <b>May 16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 9</b> , 19 <b>57</b> , and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. D. Campbell</b>		DATE SIGNED <b>May 17 1957</b>	
PHYSICIAN'S NAME (Type) <b>W. D. Campbell, M.D.</b>		ADDRESS (Street, city or town, state) <b>1457th Washington St Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/20/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24. REC'D BY REGISTRAR <b>May 20 1957</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

# CERTIFICATE OF DEATH

6032

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

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MAY 23 1957

RECEIVED

OFFICE OF THE ATTORNEY GENERAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05637

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 S. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>Edward</b> Last <b>Phenix</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Beaver Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Benjamin Phenix</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-07-9080</b>	
17. INFORMANT <b>Hattie M. Phenix, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (g) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular</b> (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 mo</b> <b>2 yrs</b> <b>3 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 1.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 15, 1956</b> to <b>May 22, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>420.1</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>5/22/57</b>			
ACTUAL SIGNATURE <b>George A. Kohler</b> M.D.		PHYSICIAN'S NAME (Type) <b>George A. Kohler, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-24-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24. REC'D BY REGISTRAR <b>MAY 24 57</b>	
25. REGISTRAR'S SIGNATURE <b>Albert...</b>		26. REGISTRAR'S SIGNATURE	

# CERTIFICATE OF DEATH

STATE OF NEW YORK

MAY 24 1957

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05669

## CERTIFICATE OF DEATH

05638

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 rural Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #3</b>		d. STREET ADDRESS <b>1 RFD #3</b>	
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Ione</b> Last <b>Pike</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1897</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Augusta, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mortimoer Clipp</b>		14. MOTHER'S MAIDEN NAME <b>Lotte Mae Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Ira W. Pike, Hagerstown Rd 3, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Auncular Fibrillation</b> DUE TO (b) <b>Arterio Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>1 day</b> <b>1 yr +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>433.1 None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 15</b> , 19 <b>57</b> , to <b>May 28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>27 May</b> , 19 <b>57</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>F F Lusby</b> M.D. ADDRESS (Street, city or town, state) <b>230 N. Potomac St., Hagerstown, Md.</b> DATE SIGNED <b>29 May 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-31-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 1, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Blanch Baewere</b>			

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JUN 4 1957

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Page 4  
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05629

## CERTIFICATE OF DEATH

05639

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>36 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>26 W. Irvin Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Berry</b> Last <b>Plummer</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>	
11. BIRTHPLACE (State or foreign country) <b>Bridgeport Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Eakle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>220-34-1032</b>	
17. INFORMANT Address <b>Mrs. Eva Price Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bone Sarcoma (Primary) 2" Lumbar Vertebra</b> <b>196x</b> DUE TO (b) <b>2 mm f</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>731x Pagets Disease of Bone - 3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Mar</b> , 19 <b>57</b> , to <b>25 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 Mar 57</b> , 19 <b>57</b> , and that death occurred at <b>2:40a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		ADDRESS (Street, city or town, state) <b>230 N Potomac</b> DATE SIGNED <b>27 May 57</b>	
PHYSICIAN'S NAME (Type) <b>Frank F. Lusby</b>		<b>230 N. Potomac St. Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-28-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Myersville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blackbowers</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05630

# CERTIFICATE OF DEATH

Reg. Dist. No.

05641

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 WKS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		d. STREET ADDRESS <b>RT. #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ESTHER</b> First Middle Last <b>RENNER</b>		4. DATE OF DEATH <b>MAY</b> Month Day Year <b>23</b> 19 <b>57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/1891</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMANUEL GIFFIN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JOHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. VEDA SCHRIVER</b>		RT. #2 <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asplenia</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET OF DEATH <b>7 days</b> <b>1 yr.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>241X</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 3</b> , 19 <b>57</b> , to <b>May 28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>11:30</b> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>159 W. Washington St., Hagerstown, Md. 5/25/57</b>			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/27/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SAMPLES MANOR CHURCH</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Korman</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	



MAY 31 1957

RECEIVED

BUREAU A. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal of remains. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal of remains.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05631

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells

05642

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. County Hospital</b>		d. STREET ADDRESS <b>2800 Quebec St N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE EVA RICE</b>		4. DATE OF DEATH Month Day Year <b>May 1 1957 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28 1906</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personelle Walter Reed Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homewood Franklin Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Kas.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis C. Rice</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Hawkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-42-6792</b>	
17. INFORMANT <b>Mrs Nellie R. Lakin</b>		Address <b>3014 Weldon Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO <b>Open fracture lt. knee</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Closed fracture lt elbow and clavicle</b> DUE TO <b>Hemorrhage and shock</b> (c)		Fresno California INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:00 p.m. 4-28- 19 57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural- Clearspring Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-1-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery Ottawa Franklin Co Kansas</b>		22d. LOCATION (City, town, or county) (State) <b>Highland Cemetery Ottawa Franklin Co Kansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 4 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>			

RECEIVED

MAY 7 1957

BUREAU V. B.

05632

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>21 Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>268 Frederick St</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash ngton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>1 268 Frederick St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SYLVESTER BURTRAM RICKETT</b>		4. DATE OF DEATH Month Day Year <b>May 7 1957 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 7 1890</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder Potomac- Edison Garage</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Springfield Clark Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Edward Rickett</b>		14. MOTHER'S MAIDEN NAME <b>Anna Banzhof</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8066</b>	
17. INFORMANT <b>Mrs Stella D. Rickett</b>		Address <b>268 Frederick St Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Arterio Sclerosis + Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>447x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 1957, to <b>7 May</b> , 1957, that I last saw the deceased alive on <b>5 May</b> , 1957, and that death occurred at <b>9:42 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>231 N Potomac Hagerstown Md</b> DATE SIGNED <b>7 May 57</b> ACTUAL SIGNATURE <b>F F Lusby</b> M.D. PHYSICIAN'S NAME (Type) <b>F F Lusby</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank H Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAY 13 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05670

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u>		c. LENGTH OF STAY IN 1b <u>75 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Daniel</u> Last <u>Ridenour</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Smithsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Ridenour</u>		14. MOTHER'S MAIDEN NAME <u>Susan Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Earl D. Ridenour,</u>		Address <u>Cavetown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/30</u> , 19 <u>56</u> , to <u>5/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>57</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) <u>Smithsburg Md.</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>		DATE SIGNED <u>5/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Groves</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Deane</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. RELIGION		6. OCCUPATION		7. PLACE OF BIRTH		8. DATE OF BIRTH		9. DATE OF DEATH		10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CLERK	

05633

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>219 Bryan Place</u>				d. STREET ADDRESS <u>219 Bryan Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MADGE</u> Middle <u>RAYETTA</u> Last <u>RIDGLEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21 1903</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry F. Rontzahn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Hamburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3686</u>		17. INFORMANT <u>William E. Ridgley</u> Address <u>219 Bryan Pl.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Aug. 19, 1956</u> , to <u>May 4, 1957</u> , that I last saw the deceased alive on <u>April 15, 1957</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. A. Bell</u>				ADDRESS (Street, city or town, state) <u>119 N. Potomac Street</u> DATE SIGNED <u>May 6, 57</u>			
PHYSICIAN'S NAME (Type) <u>R. A. Bell</u>				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>May 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shad H Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 13 1957	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05646

05671

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring Md RFD #1</u>		c. LENGTH OF STAY IN 1b <u>70 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring Maryland RFD #1</u>		d. STREET ADDRESS <u>1 Dry Run</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dry Run</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Robinson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Faith</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Slayman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. David Robinson</u>		Address <u>Clearspring Md RFD #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 28, 1957</u> to <u>May 3, 1957</u> , that I last saw the deceased alive on <u>May 4, 1957</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>5/6/57</u> ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 8-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Clearspring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Wilkesport Md</u>		24a. REC'D BY REGISTRAR DATE <u>May 8-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>			



BUREAU V. J.

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH** Item 2 Film 215 5-24-57 et al. Items 18 & 20  
 05634 302  
 Reg. Dist. No.

1. PLACE OF DEATH  
 a. COUNTY **Washington** **05634** **MARYLAND**  
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hagerstown**  
 c. LENGTH OF STAY IN 1b **2 Weeks**  
 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **Wash. County Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
 a. STATE **Maryland** b. COUNTY **Washington**  
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Boonsboro Hagerstown 03**  
 d. STREET ADDRESS **260 Hagen Street**  
 e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last **NETTIE** **ROHRER**  
 4. DATE OF DEATH Month Day Year **May 10 1957** 19 **19**

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH **Oct 6 1860** 9. AGE (In years last birthday) **96** yrs. 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housework** 10b. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (State or foreign country) **Md** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Elias Rohrer** 14. MOTHER'S MAIDEN NAME **Susan Miller**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give war or dates of service) **none** 17. INFORMANT **Records** Address **Fahrney-Keedy Mem. Home Boonsboro Md.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Generalized arteriosclerosis**  
 450.0 **5 yrs**  
 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) **Fractured Hip -**  
**5 days**  
 (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **903.7** 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) **Confused @ senility - fell while walking from chair to bed**

20c. TIME OF INJURY Month, Day, Year **6 May 5, 1957** 20d. INJURY OCCURRED While ☐ Not while ☒ at work **Fahrney-Keedy home Boonsboro Wash. Md.** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Fahrney-Keedy home Boonsboro Wash. Md.** 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **April 1, 1957**, to **May 10, 1957**, that I last saw the deceased alive on **May 9, 1957**, and that death occurred at **3 A.M.** from the causes and on the date stated above.  
 ADDRESS (Street, city or town, state) **Boonsboro Md.** DATE SIGNED **5/11/57**  
 ACTUAL SIGNATURE **G. W. HeVan** M.D. **Boonsboro Md.**  
 PHYSICIAN'S NAME (Type) **G. W. HeVan**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **5/13/57** 22c. NAME OF CEMETERY OR CREMATORY **Ross Hill Cemetery** 22d. LOCATION (City, town, or county) (State) **Hagerstown Wash. Co Md.**

23. FUNERAL DIRECTOR'S SIGNATURE **Andrew K. Coffman** ADDRESS **Hagerstown Md.** 24a. REC'D BY REGISTRAR **May 16 1957** 24b. REGISTRAR'S SIGNATURE **Phyllis H. Bowers**

RECEIVED

05635

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. STREET ADDRESS <b>438 Salem Ave.,</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Roberta</b> Last <b>Ruck</b>				4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1928</b>	
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Nathan J. Souders</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Zimmerman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-24-7519</b>		17. INFORMANT <b>Vincent Ruck</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Mammary Gland metastasis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/29/57</b> to <b>5/3/57</b> , that I last saw the deceased alive on <b>3/29/57</b> , 19 <b>57</b> , and that death occurred at <b>1077</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Reph T. Jones</b> M.D. <b>William J. Smith</b> <b>5/3/57</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blas H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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*E. coli*, *Salmonella*, *Shigella*

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1953

• **BY** 2003/2004

925-45-812

Wavelength (nm)

BUREAU V. S.

JUN 12 1957

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05636

CERTIFICATE OF DEATH

05648

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>425 McDowell Ave.,</b> 1	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J</b> Last <b>Ruth</b>		4. DATE OF DEATH Month <b>5</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1888</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Ruth</b>		14. MOTHER'S MAIDEN NAME <b>Mary C. Eichelberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-10-2675</b>	
17. INFORMANT <b>Mrs. Lillian Ruth</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411X Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Calcific aortic stenosis (rheumatic)</b> DUE TO (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/3, 1940</b> , to <b>5/14, 1957</b> , that I last saw the deceased alive on <b>5/13, 1957</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 West Washington St., Hagerstown, Md.</b> DATE SIGNED <b>5:15:57</b>			
ACTUAL SIGNATURE <b>John H. Hornbaker</b> M.D.			
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-16-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 17, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wash Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Name of Deceased <b>William Smith</b>		Sex <b>Male</b>		Age <b>21-22</b>		Date of Death <b>May 2, 1957</b>		Place of Death <b>Home</b>		Cause of Death <b>Heart Disease</b>	
Residence <b>422 McDowell Ave., Baltimore, Md.</b>		Occupation <b>Student</b>		Marital Status <b>Single</b>		Date of Birth <b>May 2, 1935</b>		Time of Death <b>10:00 AM</b>		Physician's Name <b>Dr. J. H. Smith</b>	
Signature of Physician <b>Dr. J. H. Smith</b>		Signature of Registrar <b>John W. Smith</b>		Signature of Informant <b>John W. Smith</b>		Signature of Deceased <b>William Smith</b>		Signature of Family <b>John W. Smith</b>		Signature of Friend <b>John W. Smith</b>	
Name of Informant <b>John W. Smith</b>		Address of Informant <b>422 McDowell Ave., Baltimore, Md.</b>		Relationship to Deceased <b>Brother</b>		Signature of Informant <b>John W. Smith</b>		Signature of Informant <b>John W. Smith</b>		Signature of Informant <b>John W. Smith</b>	
Name of Registrar <b>John W. Smith</b>		Address of Registrar <b>422 McDowell Ave., Baltimore, Md.</b>		Relationship to Deceased <b>Brother</b>		Signature of Registrar <b>John W. Smith</b>		Signature of Registrar <b>John W. Smith</b>		Signature of Registrar <b>John W. Smith</b>	

BUREAU V. 4

MAY 20 1957

RECEIVED

NOB HILL

5-10-57

Baltimore, Md.

John W. Smith

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

05672

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R 4</b>		c. LENGTH OF STAY IN TB <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 Hagerstown Route 4</b>	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Clayton</b> Last <b>Sauders</b>		4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1870</b>
9. AGE (In years lost birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired organ builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mallers</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Sauders</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-3428</b>	
17. INFORMANT <b>Carl O. Sheppard</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Generalized Arterio Sclerosis with</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial failure</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 1945, to <b>21 May</b> , 1957, that I last saw the deceased alive on <b>19 May</b> , 1957, and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		ADDRESS (Street, city or town, state) <b>230 W Potomac</b>	
PHYSICIAN'S NAME (Type) <b>FF Lusby</b>		DATE SIGNED <b>21 May 57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Edwards</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased <b>John</b>		Sex <b>Male</b>		Race <b>White</b>		Date of Birth <b>1930</b>		Place of Birth <b>Washington, D.C.</b>		Date of Death <b>May 27, 1957</b>	
Usual Residence <b>Washington, D.C.</b>		Cause of Death <b>Heart Disease</b>		Manner of Death <b>Natural</b>		Occupation <b>Engineer</b>		Education <b>High School</b>		Marital Status <b>Married</b>	
Signature of Physician <b>Dr. J. C. Shepherd</b>		Signature of Coroner <b>Carl C. Shepherd</b>		Signature of Registrar <b>Carl C. Shepherd</b>		Signature of Burial Director <b>Carl C. Shepherd</b>		Signature of Undertaker <b>Carl C. Shepherd</b>		Signature of Funeral Home <b>Carl C. Shepherd</b>	
Date of Burial <b>May 28, 1957</b>		Place of Burial <b>Washington, D.C.</b>		Funeral Home <b>Carl C. Shepherd</b>		Burial Director <b>Carl C. Shepherd</b>		Undertaker <b>Carl C. Shepherd</b>		Funeral Home <b>Carl C. Shepherd</b>	

BUREAU V. 5

MAY 27 1957

RECEIVED

First Name

5-27-57

Serial

John C. Shepherd

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05637

## CERTIFICATE OF DEATH

05650

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>432 N. Mulberry St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Carter Shue</u>		4. DATE OF DEATH <u>May 29 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1957</u>
9. AGE (In years, last birthday) <u>1</u> yrs. <u>1</u> month <u>29</u> days <u>29</u> hours <u>29</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd Bruce Shue</u>		14. MOTHER'S MAIDEN NAME <u>Muriel Gladys Hanson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Lloyd B. Shue</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Abertans (Hyaline Membran)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>24 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-28</u> 1957, to <u>5-29</u> 1957, that I last saw the deceased alive on <u>5-29</u> 1957, and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Margaret Sullivan</u> M.D.		ADDRESS (Street, city or town, state) <u>314 N. P. Chinnick St</u> DATE SIGNED <u>5-29-57</u>	
PHYSICIAN'S NAME (Type) <u>E. MARGARET SULLIVAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Korman</u> ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>May 31 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

2081275XVV



## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

JUN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05673

05651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE <b>No Carolina</b> COUNTY <b>Rowan</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c. LENGTH OF STAY IN 1b <b>1 Week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanatorium</b>				d. STREET ADDRESS <b>2111 West Innes St</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MARY</b> Last <b>SLAGEN</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 1 1871</b>		9. AGE (In years last birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Own Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Taneytown York Co Pa</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>John Bair</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Howard E. Slagen 2111 W. Innes St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Stasis type</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerotic heart disease</b> DUE TO (c) <b>Salisbury No Car.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>22 May</b> , 19 <b>57</b> , to <b>25 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 May</b> , 19 <b>57</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Haal</b>				ADDRESS (Street, city or town, state) <b>38 W. Patoma Street</b>		DATE SIGNED <b>27 May 57</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HANK, M.D.</b>				<b>Williamsport, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Littlestown Adams Co Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>June 3-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>E. M. Gray</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED <b>John Smith</b>		AGE <b>45</b>		SEX <b>Male</b>		RACE <b>White</b>		DATE OF BIRTH <b>May 22 1912</b>		PLACE OF BIRTH <b>St. Louis, Mo.</b>	
MANNER OF DEATH <b>Heart Disease</b>		CAUSE OF DEATH <b>Coronary Artery Disease</b>		IMMEDIATE CAUSE <b>Myocardial Infarction</b>		INTERMEDIATE CAUSE <b>Arteriosclerosis</b>		FUNDAMENTAL CAUSE <b>Arteriosclerosis</b>		OTHER CAUSE <b>None</b>	
DATE OF DEATH <b>June 10 1957</b>		PLACE OF DEATH <b>Home</b>		OCCUPATION <b>Engineer</b>		EDUCATION <b>High School</b>		RELIGION <b>Methodist</b>		MARRIAGE <b>Married</b>	
NAME OF PHYSICIAN <b>Dr. J. H. Smith</b>		NAME OF HOSPITAL <b>None</b>		NAME OF NURSE <b>None</b>		NAME OF ASSISTANT <b>None</b>		NAME OF ATTENDING <b>None</b>		NAME OF CORONER <b>None</b>	
NAME OF FUNERAL HOME <b>None</b>		NAME OF BURIAL PLACE <b>None</b>		NAME OF CEMETERY <b>None</b>		NAME OF INTERMENT <b>None</b>		NAME OF CREMATION <b>None</b>		NAME OF REINTERMENT <b>None</b>	

BUREAU V. S.

JUN 5 1957

RECEIVED

05674

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>				c. LENGTH OF STAY IN 1b <u>90 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u> <u>X2</u>			
				d. STREET ADDRESS <u>MAIN ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>W.</u> Last <u>SNYDER</u>				4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12 1867</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM B. SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA E. GROSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>GEORGE G. SNYDER</u>		Address <u>CLEAR SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION ACUTE WITH MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 4</u> , 19 <u>57</u> , to <u>MAY 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 16</u> , 19 <u>57</u> , and that death occurred at <u>9.45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>				CLEAR SPRING, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>				ADDRESS <u>Clear Spring, Md</u>		24a. REC'D BY REGISTRAR DATE <u>May 21-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murphy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. EDUCATION [Faint text]		9. RELIGION [Faint text]		10. RACE [Faint text]		11. COLOR [Faint text]		12. SEX OF DECEASED [Faint text]		13. SEX OF DECEASED [Faint text]		14. SEX OF DECEASED [Faint text]		15. SEX OF DECEASED [Faint text]		16. SEX OF DECEASED [Faint text]		17. SEX OF DECEASED [Faint text]		18. SEX OF DECEASED [Faint text]		19. SEX OF DECEASED [Faint text]		20. SEX OF DECEASED [Faint text]		21. SEX OF DECEASED [Faint text]		22. SEX OF DECEASED [Faint text]		23. SEX OF DECEASED [Faint text]		24. SEX OF DECEASED [Faint text]		25. SEX OF DECEASED [Faint text]		26. SEX OF DECEASED [Faint text]		27. SEX OF DECEASED [Faint text]		28. SEX OF DECEASED [Faint text]		29. SEX OF DECEASED [Faint text]		30. SEX OF DECEASED [Faint text]		31. SEX OF DECEASED [Faint text]		32. SEX OF DECEASED [Faint text]		33. SEX OF DECEASED [Faint text]		34. SEX OF DECEASED [Faint text]		35. SEX OF DECEASED [Faint text]		36. SEX OF DECEASED [Faint text]		37. SEX OF DECEASED [Faint text]		38. SEX OF DECEASED [Faint text]		39. SEX OF DECEASED [Faint text]		40. SEX OF DECEASED [Faint text]		41. SEX OF DECEASED [Faint text]		42. SEX OF DECEASED [Faint text]		43. SEX OF DECEASED [Faint text]		44. SEX OF DECEASED [Faint text]		45. SEX OF DECEASED [Faint text]		46. SEX OF DECEASED [Faint text]		47. SEX OF DECEASED [Faint text]		48. SEX OF DECEASED [Faint text]		49. SEX OF DECEASED [Faint text]		50. SEX OF DECEASED [Faint text]		51. SEX OF DECEASED [Faint text]		52. SEX OF DECEASED [Faint text]		53. SEX OF DECEASED [Faint text]		54. SEX OF DECEASED [Faint text]		55. SEX OF DECEASED [Faint text]		56. SEX OF DECEASED [Faint text]		57. SEX OF DECEASED [Faint text]		58. SEX OF DECEASED [Faint text]		59. SEX OF DECEASED [Faint text]		60. SEX OF DECEASED [Faint text]		61. SEX OF DECEASED [Faint text]		62. SEX OF DECEASED [Faint text]		63. SEX OF DECEASED [Faint text]		64. SEX OF DECEASED [Faint text]		65. SEX OF DECEASED [Faint text]		66. SEX OF DECEASED [Faint text]		67. SEX OF DECEASED [Faint text]		68. SEX OF DECEASED [Faint text]		69. SEX OF DECEASED [Faint text]		70. SEX OF DECEASED [Faint text]		71. SEX OF DECEASED [Faint text]		72. SEX OF DECEASED [Faint text]		73. SEX OF DECEASED [Faint text]		74. SEX OF DECEASED [Faint text]		75. SEX OF DECEASED [Faint text]		76. SEX OF DECEASED [Faint text]		77. SEX OF DECEASED [Faint text]		78. SEX OF DECEASED [Faint text]		79. SEX OF DECEASED [Faint text]		80. SEX OF DECEASED [Faint text]		81. SEX OF DECEASED [Faint text]		82. SEX OF DECEASED [Faint text]		83. SEX OF DECEASED [Faint text]		84. SEX OF DECEASED [Faint text]		85. SEX OF DECEASED [Faint text]		86. SEX OF DECEASED [Faint text]		87. SEX OF DECEASED [Faint text]		88. SEX OF DECEASED [Faint text]		89. SEX OF DECEASED [Faint text]		90. SEX OF DECEASED [Faint text]		91. SEX OF DECEASED [Faint text]		92. SEX OF DECEASED [Faint text]		93. SEX OF DECEASED [Faint text]		94. SEX OF DECEASED [Faint text]		95. SEX OF DECEASED [Faint text]		96. SEX OF DECEASED [Faint text]		97. SEX OF DECEASED [Faint text]		98. SEX OF DECEASED [Faint text]		99. SEX OF DECEASED [Faint text]		100. SEX OF DECEASED [Faint text]	
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BUREAU V. 81

APR 23 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05638

CERTIFICATE OF DEATH

05653

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>339 Elizabeth Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>VIOLA</b> Last <b>SQUIBB</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1885</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mechanicsburg, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Frank W. Gelwicks</b>		14. MOTHER'S MAIDEN NAME <b>Harriett V. Neff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Margaret Redmond</b> Address <b>9 Madison Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, cause unknown</b> <b>053.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>904.9</b> (b) <b>Undernutrition</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, Fracture left humerus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>3-4 months</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>16 Mar., 1957</b> , to <b>26 April, 1957</b> , that I last saw the deceased alive on <b>26 April, 1957</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1135 POTOMAC AVENUE</b> DATE SIGNED <b>4 MAY 57</b> ACTUAL SIGNATURE <b>Richard T. Binford</b> M.D. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b> <b>HAGERSTOWN, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mechanicsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mechanicsburg Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 4, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. C. Frost via Rec.</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
MAY 7 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		DR. JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS	
I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.		I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.		I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.		I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.		I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.		I, the undersigned, being a competent witness to the death of the deceased, do hereby certify that the foregoing is a true and correct statement of the facts and circumstances of the death.	

BUREAU V. A.

MAY 7 1968

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05639

## CERTIFICATE OF DEATH

05654

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1531 Dual Highway Hag. Md.</b>				e. STREET ADDRESS <b>1531 Dual Highway Hagerstown</b>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Cocoran</b> Last <b>Steffey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1884</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>21</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Chief Clerk Hillman Coal &amp; Coke Co.</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Mc Kendrick Steffey</b>				14. MOTHER'S MAIDEN NAME <b>Rose Sheets</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>192-10-6338</b>		17. INFORMANT <b>Mrs. Blanche Steffey</b> Address <b>1531 Dual Highway Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio vascular disease</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic heart disease with multiple valvular defects.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>416x</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Hour <b></b> o. m. <b></b> p. m. <b>19</b> Month <b></b> Day <b></b> Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I attended the deceased from <b>Feb. 25</b> , 19 <b>55</b> to <b>May 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 6</b> , 19 <b>57</b> , and that death occurred at <b>11:45 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg.,</b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>W. T. Layman</b>				M.D. <b>William T. Layman, M. D.,</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M. D.,</b>				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter L. Williamsport, Md.</b>				24a. REC'D BY REGISTRAR <b>May 31, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Bowers</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 2

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05640

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
c. LENGTH OF STAY in 1b <u>2 yrs</u>				d. STREET ADDRESS <u>16 South Carlisle st</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Conv. Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Jane</u> Last <u>Summers</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Gossard</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rumel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Earl Summers, Greencastle, Pa</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Anoxia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334x</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>3 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>May 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>57</u> , and that death occurred at _____ M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Shady Grove, Pa.</u> DATE SIGNED <u>6/1/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Hess, M. D.</u>				<u>Shady Grove, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kauffman Station Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Franklin Co. Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Zimmerman</u> ADDRESS <u>Greencastle, Pa.</u>				24a. REC'D BY REGISTRAR <u>June 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	



CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *12/12/1912*

5. PLACE OF BIRTH: *John Doe*

6. OCCUPATION: *John Doe*

7. CAUSE OF DEATH: *John Doe*

8. PLACE OF DEATH: *John Doe*

9. DATE OF DEATH: *John Doe*

10. SIGNATURE OF DECEASED: *John Doe*

11. SIGNATURE OF WITNESS: *John Doe*

12. SIGNATURE OF PHYSICIAN: *John Doe*

13. SIGNATURE OF CORONER: *John Doe*

14. SIGNATURE OF BURIAL OFFICIAL: *John Doe*

15. SIGNATURE OF OTHER: *John Doe*

RECEIVED  
JUN 12 1957  
BUREAU V. 8

05641

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

05655

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>409 George St.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Glendora</b> Middle <b>Edna</b> Last <b>Swope</b>				4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1881</b>		9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hag. Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Wm. Swope</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Allison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-8238</b>		17. INFORMANT <b>John E. Swope</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>arteriosclerotic myocardial heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>myocardial failure grade Iv</b> (c) <b>lyr.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>None</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>April 15, 19 57</b> , to <b>May 6, 19 57</b> , that I last saw the deceased alive on <b>May 6, 19 57</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>		DATE SIGNED <b>5-6-57</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>May 8, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• **Stress**

[illegible]

1994

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Washington County

George W. Jones

*novella d'ordine*

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J. L. P. 9708

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**BUREAU**

MAY 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal.

VS. A15ME(5)  
SM 9/55

05675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05656

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -Boonsboro		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Ringgold	
3. NAME OF DECEASED (Type or print) First Middle Last Claire - Thompson		4. DATE OF DEATH Month Day Year May 11 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Moller's	
11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Motter Thompson		14. MOTHER'S MAIDEN NAME Susan Hahn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-1387	
17. INFORMANT Address Mrs. Claire Thompson- R # 5 Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic coronary heart disease (c) DUE TO 1 yr		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57	
22c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Address Walter Y. Grove, Waynesboro, Pa.		24a. REC'D BY REGISTRAR DATE 5/10/57	
24b. REGISTRAR'S SIGNATURE John Bast			

RECEIVED



05642

## CERTIFICATE OF DEATH

Reg. Dist. No.

05657  
302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>103 BELVIEW AVE.</b>		d. STREET ADDRESS <b>1 103 BELVIEW AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MARIE</b> Last <b>TOMS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BEN JAMIN DORTY</b>		14. MOTHER'S MAIDEN NAME <b>SARAH CLEVER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>LAWRENCE L. TOMS, HAGERSTOWN, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovas. collapse</b> <b>583x</b> DUE TO <b>Cystic Liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>583x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 1952</b> , to <b>May 27 1957</b> , that I last saw the deceased alive on <b>May 26 1957</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 S. Antietam St Hagerstown, Md.</b> DATE SIGNED <b>5/28/57</b>			
ACTUAL SIGNATURE <b>Louis B. Graff</b>		M.D. <b>Louis B. GRAFF MD.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hornum</b>		24a. REC'D BY REGISTRAR <b>May 31 1957</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 60		SEX M		RACE W		DATE OF DEATH JUN 3 1957	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE M		MARITAL STATUS WIDOW	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION		OTHER CAUSE NONE	
DATE OF BIRTH JUN 3 1897		PLACE OF BIRTH BALTIMORE		DATE OF DEATH JUN 3 1957		PLACE OF DEATH HOME		DATE OF DEATH JUN 3 1957	
NAME OF DECEASED JAMES H. HARRIS		AGE 60		SEX M		RACE W		DATE OF DEATH JUN 3 1957	
PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD		ZIP CODE 21201	
OCCUPATION RETIRED		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE M		MARITAL STATUS WIDOW	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION		OTHER CAUSE NONE	

DECLARATION OF DEATH  
I, the undersigned, being a duly qualified medical examiner, do hereby certify that the above-named deceased person died on the 3rd day of June, 1957, at the place of death stated above, and that the cause of death was as stated above.

SIGNATURE OF MEDICAL EXAMINER  
JAMES H. HARRIS

DATE OF SIGNATURE  
JUN 3 1957

RECEIVED  
JUN 3 1957  
BUREAU V. S.

05643

## CERTIFICATE OF DEATH

Reg. Dist. No.

05658

302

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO BENEVOLA RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARLOCK NURSING HOME</u>		d. STREET ADDRESS <u>BOONSBORO MD. R.I.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE LYDIA CATHERINE TOMS</u>		4. DATE OF DEATH Month Day Year <u>MAY 15 1957 19</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MYERSVILLE FRED.CO.MD.U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>GEORGE W. WACHTELL</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA METZGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HUBERT W. TOMS BOONSBORO MD R.I.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8,</u> 19 <u>57</u> , to <u>May 15,</u> 19 <u>57</u> , that I last saw the deceased alive on <u>May 14,</u> 19 <u>57</u> , and that death occurred at <u>10 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 S. Main St. Boonsboro, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>J. Hubert Wade</u>		M.D. <u>2 S. Main St. Boonsboro, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Hubert Wade, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>	22b. DATE THEREOF <u>MAY 17 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO MAUSOLEUM</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH.CO.MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Boonsboro Md</u>		24a. REC'D BY REGISTRAR <u>May 20 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

NAME OF DECEASED LAST NAME FIRST MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE AGE <input type="checkbox"/> YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS DATE OF BIRTH <input type="checkbox"/> JAN <input type="checkbox"/> FEB <input type="checkbox"/> MAR <input type="checkbox"/> APR <input type="checkbox"/> MAY <input type="checkbox"/> JUN <input type="checkbox"/> JUL <input type="checkbox"/> AUG <input type="checkbox"/> SEP <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC DAY <input type="checkbox"/> MONTH <input type="checkbox"/> YEAR		PLACE OF BIRTH STATE <input type="checkbox"/> DISTRICT OF COLUMBIA <input type="checkbox"/> FOREIGN <input type="checkbox"/>	
OCCUPATION TRADE, PROFESSION, OR SERVICE DATE OF DEATH <input type="checkbox"/> JAN <input type="checkbox"/> FEB <input type="checkbox"/> MAR <input type="checkbox"/> APR <input type="checkbox"/> MAY <input type="checkbox"/> JUN <input type="checkbox"/> JUL <input type="checkbox"/> AUG <input type="checkbox"/> SEP <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC DAY <input type="checkbox"/> MONTH <input type="checkbox"/> YEAR		CAUSE OF DEATH 1. <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> CORONARY ARTERY DISEASE <input type="checkbox"/> MYOCARDIAL INFARCTION 2. <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> PNEUMOTHORAX <input type="checkbox"/> EMPHYSEMA 3. <input type="checkbox"/> CANCER <input type="checkbox"/> MALIGNANT <input type="checkbox"/> BENIGN 4. <input type="checkbox"/> INFECTION <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> BRUCELLOSIS <input type="checkbox"/> SYPHILIS 5. <input type="checkbox"/> TRAUMA <input type="checkbox"/> FALL <input type="checkbox"/> FIRE <input type="checkbox"/> DROWNING <input type="checkbox"/> POISONING 6. <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNNATURAL CAUSE 7. <input type="checkbox"/> OLD AGE <input type="checkbox"/> DEGENERATION 8. <input type="checkbox"/> OTHER	
PLACE OF DEATH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/>		COUNTY OF DEATH STATE OF DEATH	
SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR SIGNATURE OF CLERK	

BUREAU V. 31

MAY 23 1957

RECEIVED

05644

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

05659

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>17 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>811 The Terrace</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>M.</u> Last <u>Tooma</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 14, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>1</u> Hours <u>8</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oriental Rugs</u>		11. BIRTHPLACE (State or foreign country) <u>Zahle, Lebanon</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Milhim Tooma</u>				14. MOTHER'S MAIDEN NAME <u>Mary Maloof</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-34-0890</u>		17. INFORMANT <u>Mrs. Sam. M. Tooma, Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 hr</u> <u>3 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>22 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 May</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>230 N. Potomac</u> DATE SIGNED <u>24 May 57</u> ACTUAL SIGNATURE <u>F. F. Lusby</u> M.D. <u>Hagerstown Md</u> PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>P. Franklin Rouzer</u>				ADDRESS <u>305 N. Potomac St.</u>		24a. REC'D BY REGISTRAR <u>May 25, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH</p>	
<p>21. SIGNATURE OF CEMETERY</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
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<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
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<p>79. SIGNATURE OF INTERVIEWER</p>		<p>80. SIGNATURE OF INTERVIEWER</p>	
<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
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<p>87. SIGNATURE OF INTERVIEWER</p>		<p>88. SIGNATURE OF INTERVIEWER</p>	
<p>89. SIGNATURE OF INTERVIEWER</p>		<p>90. SIGNATURE OF INTERVIEWER</p>	
<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

BUREAU V. 3

MAY 28 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45660

05645

Item 11 Film 6216 6-13-57 et

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg - Rural</u>		d. STREET ADDRESS <u>Smithsburg Md. R. 2.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Russel</u> Middle <u>C.</u> Last <u>Waltz</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug-9-1894</u>	
9. AGE (In years last birthday) <u>63-9-22</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u> Hours <u>22</u> Min.		IF UNDER 24 HRS. Months <u>9</u> Days <u>22</u> Hours <u>22</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co. Road Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Waltz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>217-10-3459</u>		17. INFORMANT <u>Harold Lee Waltz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>6 hrs</u> (c) <u>6 hrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 hrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. F. W. D. I. To J. R.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro Wash. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home Boonsboro Md</u>				24. REC'D BY REGISTRAR <u>June 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

05646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05661

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at home 59 Blooms Alley				d. STREET ADDRESS 59 Blooms Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Harvey Last Ware				4. DATE OF DEATH Month May Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connellsville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Ware				14. MOTHER'S MAIDEN NAME Carrie Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) World War 2 115-09-3079		17. INFORMANT Address Mrs. Jessie Manuel -Sister			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.1 DUE TO Generalized rheumstoid arthritis Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. 722.0 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr.				ADDRESS Hagerstown Md		24. REC'D BY REGISTRAR May 4, 1957	
						24b. REGISTRAR'S SIGNATURE E. H. Bowers	

RECEIVED

MAY 7 1957

BUREAU V. 3

ORIGINAL FILED



## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>52 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>43 W. Bethel Street.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Richard Watson</u>		4. DATE OF DEATH Month Day Year <u>3 3 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1987</u>		
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pullman Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Carmichael, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>John Watson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Steward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Mrs Nettie E. Watson 43 W. Bethel St.</u>			
17. INFORMANT <u>Mrs Nettie E. Watson 43 W. Bethel St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>indeterminate</u> <u>indeterminate</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 20</u> , 19 <u>57</u> , to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>W. D. Layman</u> M.D. <u>100 Professional Arts Bldg. 5-4-57</u> PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-6-1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray S. Dawson Hager, Md.</u>		24a. REC'D BY REGISTRAR <u>May 6 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05648

05663  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md.</u>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1957</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Roosevelt</u> Last <u>Williams</u>				5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1910</u>		9. AGE (In years last birthday) <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild's Aircraft Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-9465</u>		17. INFORMANT (son) <u>Paul E. Williams</u>		Address <u>Keedysville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>816X</u> DUE TO <u>Fractured skull(closed)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hemorrhage &amp; shock</u> DUE TO (c) <u>3:45 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Passenger in auto collision Route 65, 1/2 Mile N.. of Tilghmaton, Md.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto collision Route 65, 1/2 Mile N.. of Tilghmaton, Md.</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>1A</u> o. m. <u>May 4</u> 19 <u>57</u>			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt 65</u>			
20f. (City or town) <u>Hagerstown</u>				(County) <u>Wash.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Welle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Welle, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>May 5 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakersville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bakersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Williams</u>				24a. REC'D BY REGISTRAR <u>May 5, 1957</u>			
ADDRESS <u>Sharpsburg, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARKANSAS STATE DEPARTMENT OF HEALTH - BATHORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. COLOR  
9. RACE  
10. RELIGION  
11. EDUCATION  
12. PRESENT ADDRESS  
13. DATE OF DEATH  
14. PLACE OF DEATH  
15. CAUSE OF DEATH  
16. MANNER OF DEATH  
17. SIGNATURE OF EXAMINER  
18. DATE OF EXAMINATION  
19. PLACE OF EXAMINATION  
20. SIGNATURE OF WITNESS  
21. DATE OF SIGNATURE  
22. PLACE OF SIGNATURE

BUREAU V. B.

MAY 7 1957

RECEIVED

05676

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>5 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nalley's Nursing Home</b>				d. STREET ADDRESS <b>S. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT</b> First <b>J</b> Middle <b>WRIGHT</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Calhoun Co. W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William Wright</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Obed Bailey</b> Address <b>Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 1, 1957</b> to <b>May 23, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Levan</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>5/24/57</b>			
PHYSICIAN'S NAME (Type) <b>G. W. Levan</b> (G.W. Levan) <b>Boonsboro, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 26, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. G. Hook &amp; Co.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		RECEIVED		OTHER	
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		OTHER SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF NOTARY		SIGNATURE OF WITNESS		SIGNATURE OF OTHER	

BUREAU V. E.

MAY 27 1957

RECEIVED